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UNDER THE EDITORIAL DIRECTION OF

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A COSMOPOLITAN BIWEEKLY FOR THE GENERAL PRACTITIONER

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Volume XXII **AUGUST ELEVENTH** **Number 3**

Editorial Department.

The Immense Value of Scientific Biographies.

THE young man in medicine during "the waiting period," is confronted with many discouragements and perplexities. To him the pathway leading to professional success seems full of unexpected hard places, even pitfalls and seeming insurmountable obstacles. These encounters, if few or many, are sure to leave behind them marks, indellible perhaps, which in some way affect the future of the to be physician. If he allows melancholy, engendered by such experiences, to call him her own, the chances are he has had a twist in his career which may be permanent, but if he takes all such experiences as part of the whole, he is sure to be a better man and win out in the end. The innate force of character, that potential of the individual which stops at nothing, will carry him through these discouragements, even defeats to give polish to his career in the future. The seeing of footsteps of others through these same discouragements will, as Longfellow says, "gives heart again," and so it is well for the young man in medicine to early cultivate a liking for biography. Study biography and read how others have carved their careers in the face of even more formidable obstacles than his own, and won success out of them.

A writer in the *Saturday Evening Post* speaking recently of the immense value of biographies of scientific men, said that "There is one class of barks which if rightly read, seems to me to minister more than all other reading to the understanding of science, and these are the biographies of scientific men." "Thus, if one reads a history of the development of a scientific man, where enough of the man is shown to trace his real growth and to understand the real springs of action which moved him, one may trace out of the actual evolution of a scientific man and come to know, as in no other way, what the scientific spirit is. Let one take up the study of such a life as that of Pasteur and follow it from the tanner's yards in

Arbois to the inauguration of the Pasteur Institute in Paris. If catching somewhat of the simplicity and sincerity of the scientific method, he can follow this serious, simple-hearted lad through his school days and his dreary homesickness in Paris; trace the gradually forming strength of will which must know the truth and would make any sacrifice and perform any labor to attain it; follow him through those simple but exhaustive experiments in spontaneous generation; trace out his life history the influence of these first principles in biological science until they lead him to discover which have made life something better for the whole race of men; if one will in some such way trace out the growth of one of the masters in science, he will realize as in no other way, that the unselfish pursut of truth leads not only to larger usefulness, but no less truly to simplicity and nobility of life. And, after all, there is perhaps no study of science which to the intelligent reader will yield so much, will give so direct a view of the philosophy of science and of its bearing in human life, as a study of the masters of science themselves."

This is true of the lives of physicians, and especially of those men who have been the diligent workers in the progress of medical sciences. The really great man in medicine is one of the marked men with characteristics marked by simplicity, earnestness and the hopeful spirit of service which allows no discouragement to mar or thwart his real purpose in life. Every young man in medicine should read and study the lives of the great men in scientific medicine; be true followers of their simplicity, nobleness of character, and thus become themselves true disciples of the healing art.

F. P. N.

Dr. George H. Simmons.

We learn with sincere regret of the illness of Dr. George H. Simmons, the progressive and very efficient editor of the *Journal of the American Medical Association*. He was operated upon for gall-stones by Dr. M. L. Harris. The operation was successful, and it to be hoped that Dr. Simmons may have an uneventful and speedy recovery. Dr. Simmons is one of the great medical editors of today, a man judicious, painstaking and earnest in all that he undertakes. He has been a vigorous worker, a helpful, hopeful and inspiring exampler. We trust that his life may be spared many years, in order that he may lead the profession to the highest ideals and see completed the great work in professional organization he is so vigorously urging. A good editor like every "other good thing," is a blessing to humanity, consequently medical editors have the consolation that they are humanitarians; some day they will get their reward. We extend our best wishes for a speedy recovery to Dr. Simmons.

F. P. N.

Centenary Hospital.—The trustees of Barnes Medical College have almost completed their new hospital which is being erected on the lot adjoining the college. Centenary Hospital is a six-story building with accommodations for 150 patients. It is modern in every respect, there has been no sparing of money or energy in the endeavor to make it one of the best in the West.

Annual Meeting of the Medical Society of the Missouri Valley

The annual meeting of this association will be held on September 18th, at Sioux City, Iowa, and from present indications it will be one of the most interesting sessions of the year. The committee of Arrangements has assured us of a hearty welcome and liberal entertainment. The profession cordially invited. Following papers have been promised:

Vernal Catarrh, especially in Adults, H. Gifford, Omaha.
Dysmenorrhea, W. O. Henry, Omaha.
Light in the Treatment of Tuberculosis, J. W. Kime, Ft. Dodge.
Surgical Treatment of Cleft Palate, A. P. Condon, Omaha.
Ileo Colitis, W. Berry, South Omaha.
Chronic Spinal Muscular Atrophy, F. E. Coulter, Omaha.
Multiple Compound Fracture of the Skull, G. G. Cottam, Rock Rapids, Ia.
Surgical Treatment of Lesions of the Stomach, J. E. Summers, Jr., Omaha, Neb.
Vesicular Mole, Mary Strong, Omaha, Neb.
Uretero Cystostomy, A. J. McKinnon, Havelock, Neb.
Regular program will be issued September 1st.

RICHARD C. MOORE, President.
CHAS. WOOD FASSETT, Secretary.

THE GOOD SAMARITAN HOSPITAL.—For a number of years the Good Samaritan Hospital on North Jefferson Avenue, has been under homeopathic, and its career has been checkered with vicissitudes more than should have been its portion. A recent upheaval has resulted in the resignation of the staff and the trustees have inaugurated a new regieme with regular physicians in control. A strong staff is promised, and it is believed that the institution will become one of the most prominent in the city.

OUR CITY MILK INSPECTOR.—It would seem that we have at least one city official whose title is a misnomer. It is abundantly evidenced by our daily papers that our milk inspector does little inspecting, and is only in evidence after bad milk has gotten in its work and on the salary list. The milk supply of the city hospital was lately found to be an absolute menace to the health of the patients, and the source of supply was changed —this has lead to an investigation of the milk inspector's office and laboratory with anything but satisfactory results.

CRUDE PETROLEUM AND MOSQUITOES.—Councilman Hodges introduced a bill in the municipal assembly, providing for a coating of oil on stagnant pools in various sections of the city, which was duly passed. The purpose of the bill was the elimination of mosquitoes and consequent malaria. But in spite of the fact that science has demonstrated the connection between the mosquito and malaria and between petroleum and the mosquito—certain of our health officials are obstructing the operation of the bill, and ridiculing its intent. We do have the "most darndest" bad luck with some of our officials.

The Reviewer's Table.

Books, Reprints, and Instruments for this department, should be sent to the Editors, St. Louis.

OPHTHALMIC MYOLOGY. A systematic treatise on the ocular muscles. By G. C. Savage, M. D., Professor of Ophthalmology in the Medical Department of Vanderbilt University; author of "New Truths in Opthalmology," etc. 61 cuts and 6 plates. Nashville, Tenn.: Gospel Advocate Publishing Co. (Price, $4.00.)

The author of this volume handles the complicated problems in which the ocular muscles are concerned with a familiarity which makes all appear simple and easy of comprehension, and in this lies the chief strength of the work. It easily stands with the very best that has been written on the subject. Dr. Savage is evidently a deep thinker and an enthusiastic worker, and possesses the happy faculty of imparting his enthusiasm to his readers. In this work he gives a comprehensive presentation of the normal working of the ocular muscles and the various possible variations therefrom with careful consideration of methods of correction. Considerable that is original with the author is propounded, in every instance where he varies from accepted theories he defends his position in so convincing a manner that we welcome his deflection. The book will be found worthy of deep study by ophthalmologists and all who are especially interested in eye work.

PHOTOGRAPHIC ATLAS OF DISEASES OF THE SKIN. By George Henry Fox, A.M., M.D., Parts XII and XIII. Philadelphia: J. B. Lippincott Co., publishers.

Each number of this series of atlases adds to our previously expressed pleasure with it. Numbers 12 and 13, the latest received, considers Erythema, Lichen, Vascular Naevus, Trichophytosis, Eczema Impetiginosum, Facial Erysipelas, Hereditary Syphilis, Elephantiasis and Xanthoma. The plates are superb. No physician can afford to be without the series, either the text or the illustrations are well worth the cost.

A PRACTICAL TREATISE ON SMALLPOX. Illustrated by Colored Photographs from life. By George Henry Fox, A.M., M. D., Consulting Dermatologist to the Health Department of New York City, with the Collaboration of S. D. Hubbard, M.D., S. Pollitzer, M.D., and J. H. Huddleston, M.D. In two parts. Philadelphia and London: J. B. Lippincott Company, 1902. (Price, $3.00.)

In connection with the above we are pleased to be able to give attention to these two atlases, which are gotten out in uniform style with the skin atlases, are by the same authority and being on a subject so closely associated would naturally seem to be a part of the series which they make complete. Very few physicians have served time in a quarantine hospital, and the responsibility of diagnosing small pox in its early course and

without error is of great importance. The illustration and text of these two atlases will familiarize all readers with this disease; the text is excellent, it is brief and eminently practical, giving the course of the disease, points of diagnosis and methods of treatment. The chapter on vaccination, giving technique and possible complications is worthy of mention. But the feature of the work is illustration. In skin and associated diseases nothing talks as do photographs and drawings, and never have these been more skillfully reproduced in colors true to life than in this series.

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Diseases of the Intestines. Their Special Pathology, Diagnosis, and Treatment, with Sections on Anatomy and Physiology, Microscopic and Chemic Examination of the Intestinal Contents, Secretions, Feces and Urine; Intestinal Bacteria and Parasites; Surgery of the Intestines; Dietetics, Diseases of the Rectum, etc. By John C. Hemmeter, M.D., Ph. D., Professor in the Medical Department of the University of Maryland; Consultant to the University Hospital and Director of the Clinical Laboratory. Special Sections on Anatomy, Bacteria of the Intestines, Diseases of the Rectum, and the Examination of Urines and Feces, contributed by Dr. J. Holmes Smith, Baltimore, Md.; Dr. William Royal Stokes, Baltimore, Md.; Dr. Thomas C. Martin, Cleveland, O., and Dr. Harry Adler, Baltimore, Md. With many full-page plates, colored and other illustrations, most of which are Original. 2 vols. Philadelphia: P. Blakiston's Son & Co. (Price, Cloth, $5.00; Sheep, $6.00, net.)

It is difficult to select special features of an excellent book. It is even more difficult to criticise an excellent book. Hemmeter seems to have been so extremely and uniformly successful in this exhaustive treatise that one can only praise it after reading its pages. It is a work that cannot be read at a sitting, nor in a dozen sittings, for it is all so thoroughly scientific and exhaustive that it must be read slowly and digested. In comparison with other works on the subject, this one takes first place, first by reason of its originality, and second, because of the exhaustive study of the literature of the subject. We have been delayed in reviewing this work, but not to its detriment, for in the meantime the second volume has appeared to complete the treatise. Thus giving as a whole one of the epoch-marking books of this year. In this treatise are considered all of the diseases of the intestines, in all of their clinical and pathological features. So complete is the work that no less an authority than Nothnagel has commended it in the following apt and expressive way:

"In the warmest manner I wish to thank you for the kind presentation of the second volume of your classical work on 'Diseases of the Intestines.' I may say that I am reading this volume, also, with great interest. It is written with extraordinary knowledge of the literature. It is clear, comprehensive, complete and scholarly; and everywhere the individual judgment based upon personal experience is evident alongside with the objective appreciation of the achievements of others. I believe to say the best that can be said when I assert that the book in all its parts gives evidence that you are a solid, reliable worker."

We believe this work first to be studied thoroughly, then ready at hand for reference, should be in the library of every physician. We congratulate the publishers on the excellence of their work. F. P. N.

VAUGHAN AND NOVY ON CELLULAR TOXINS. A treatise on Cellular Toxins, or the Chemical Factors in the Causation of Disease. By Victor C. Vaughn, Ph.D., M. D., Professor of Hygiene and Physiological Chemistry, and Frederick G. Novy, M.D., Junior Professor of Hygiene and Physiological Chemistry in the University of Michigan. New (4th) edition, revised and enlarged. In one 8vo volume of 480 pages, with 6 illustrations. Philadelphia and New York: Lea Brothers & Co, Publishers, 1902. (Cloth, $3.00, net.)

This edition presents a new work rather than a revision. The knowledge of the chemistry of the infectious diseases has changed and developed so much during the past few years, that not only was it necessary completely to re-write this book, but its title had to be changed to conform more appropriately to the accepted facts of today. Cell-poisoning is now recognized as the starting point of the infectious diseases, and into this modern investigation is bringing the majority of human ills. It is now proved that micro-organisms act not only directly, but by the synthetic substances formed within their own cells. The importance of a knowledge of these facts in the cure and prevention of disease is obvious, and the intelligent interest shown in the subject is indicated by the demand for a fourth edition of this unique work—the standard authority. This work, in connection with Dr. Charles Simon's recent work on Physiological Chemistry, and Dr. Herter's volume on Chemical Pathology, furnishes a complete and satisfactory library of present-day knowledge in medical chemistry.

ATLAS AND EPITOME OF SPECIAL PATHOLOGIC HISTOLOGY. By Docent Dr. Hermann Durck, of the Pathologic Institute of Munich. Edited by Ludvig Hektoen, M.D., Professor of Pathology in Rush Medical College, Chicago. Vol II.—Liver; Urinary Organs; Sexual Organs; Nervous System; Skin; Muscles; Bones. With 123 colored illustrations on 60 lithographic plates and 192 pages of text. Philadelphia and London: W. B. Saunders & Co., 1901. (Cloth, $3.00 net.)

This volume being the second of this series, completes the Special Pathologic Histology. Like its companion volume it contains many elegant colored plates. The illustrations are equal to any, for which the Saunders' hand atlases are so highly prized. The tissue changes with the differential staining are accurately reproduced. These two volumes offer a clinic more extensive and more varied than it would require years of clinical laboratory work to obtain. The text, though brief, covers the subject extensively. There is no "stuffing"; every word is valuable. It is a thoroughly practical working manual of pathology.

MORPHINISM AND NARCOMANIA from Opium, Cocain, Ether, Chloral, Chloroform, and other Narcotic Drugs; also the Etiology, Treatment and Medico-Legal Relations. By T. D. Crothers, M.D., Superintendent of Walnut Lodge Hospital, Conn.; Professor of Mental and Nervous Diseases, New York School of Clinical Medicine, etc. Handsome 12mo of 351 pages. Philadelphia and London: W. B. Saunders & Co., 1902. (Cloth $2.00, net.)

The alarming increase, in the last few years, of morphomania and the associated various narcomanias imperatively demands immediate attention by the medical profession. Every year the increasing prominence of this psychosis calls for more exact studies, with a fuller recognition of the conditions and causes of the disease. Medicolegally, questions of responsibility have been asked with increasing frequency, and there has been no literature and no study of the subject to afford an intelligent answer until this present time was initiated. The special object of this work has been to group the general facts and outline some of the causes and symptoms common to most cases, and to suggest general methods of treatment and prevention. The object could not have been better accomplished. The work gives a general preliminary survey of this new field of psycopathy, and points out the possibilities from a larger and more accurate knowledge and so indicates degrees of curability at present unknown. The author shows his absolute familiarity with his subject in the clear, concise, and in every way admirable work which he has given to the profession, whom he has placed under merited obligations.

THE DRUG HABITS AND THEIR TREATMENT. A Clinical Summary of some of the General Facts Recorded in Practice. By T. D. Crothers, M. D., Superintendent Walnut Lodge Hospital, Hartford, Conn., Professor Diseases of the Brain and Nervous System, New York School of Clinical Medicine. Pages 96. Chicago: G. P. Engelhard & Company, 1902. (Price, $1.00, net.)

This book represents concisely the views of this well known author. It is a valuable clinical guide and worthy of study by all physicians who are called upon to treat such diseases. Crothers is perhaps the leading English speaking authority on drug habits, hence the value of his writings.

F. P. N.

DOSE-BOOK AND MANUAL OF PRESCRIPTION WRITING. With a list of the Official Drugs and Preparations, and the More Important Newer Remedies. By E. Q. Thornton, M.D., Demonstrator of Therapeutics, Jefferson Medical College, Philadelphia. Second edition, revised and enlarged. Illustrated. Philadelphia and London: W. B. Saunders & Co., 1901. (Bound in flexible leather, $2 net.)

Every student of medicine should be thoroughly instructed in the art of prescribing. This course of instruction should include dosage, combinations of drugs and prescription writing. Such knowledge is absolutely essential to the physician's usefulness as a practitioner. This compact

manual, so carefully compiled and edited, is the best book of its kind on the market. The student will find in concise simplified form the facts necessary to have at command in formulating a prescription. Prescription writing need not become a lost art with Thornton's Manual at hand. Young physicians must study art and architecture of prescription writing, for truly it is often the gate-way leading to introduction through the kindly medium of a good druggist. Again, if in communities where physicians are their own druggists, it gives strength and ability to prescribe properly. We heartily commend this excellent manual.

THE MEDICAL NEWS POCKET FORMULARY FOR 1902. By E. Quin Thornton, M.D., Demonstrator of Therapeutics, etc., in the Jefferson Medical College, Philadelphia. Fourth edition, revised. 1902. Philadelphia and New York: Lea Brothers & Co.

This excellent formulary has been revised and brought up to date. It is a most convenient and serviceable book, and will be of great help, especially to the young practitioner. The special prescriptions are standard and have stood the best of experience.

A BRIEF OF NECROSCOPY AND ITS MEDICO-LEGAL RELATIONS. By Gustav Schmitt, M. D. New York and London. Funk & Wagnalls Company. (Price, leather, $1.00 net.)

This pocket manual has been prepared to meet the special needs of physicians, lawyers and expert witnesses. It supplies in brief form, and yet with every essential detail, all practical facts connected with the study, diagnosis, technique and the medico-legal aspect of a post-mortem examination. To the physician the advantage of the book is apparent. The suddenness of a call to make a post-mortem examination leaves little time for him to post himself on the subject. It is unpleasant as well as inconvenient to carry along a medical library for reference. By reason of its size, Dr. Schmitt's little manual can always be slipped into the pocket to serve as a complete guide for whatever emergency may arise. It also means to the physician protection from the law. It is of great value when he makes a section and again when he reports upon the case. It prepares him to give testimony, and so saves him from the badgering of attorneys and the criticism of the general public. On the other hand, it assists the attorney in cross-examination, especially upon the points as to whether the post-mortem was conducted according to law, and whether the diagnosis was correct. To the expert witness it is a post-mortem in a nutshell.

MAN'S HEIGHT AND WEIGHT.—A careful inquiry into the average height of the different nations has shown the English professional classes to be the tallest adult males, attaining the high average of 5 feet 9.14 inches. Next on the list come the Englishmen. Thus, the English and American nations are approximately of the same height. Most European nations average 5 feet 6 inches for the adult male, while Australians, Spanish and Portugese fall below this.

Original Department.

PAPERS for the Original Department should be in hand one month in advance, and contributed to THE MEDICAL FORTNIGHTLY exclusively. A liberal number of extra copies will be furnished authors, and reprints may be obtained at reasonable rates, if request accompanies the manuscript. Engravings from photographs furnished free.

Contributions, and books for review, should be sent to the Editors, 312 Century Building, St. Louis.

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What is the Obstetrician's Duty?

By Florence Patrick, M. D.

BURLINGTON, IOWA.

Read before the Tri-State Medical Society at Chicago, April 4, 1902.

THE subject matter which we have at our hand regarding the technique of the conduct and management of obstetric work is abundant.

The necessity for the general adoption of these advantages which, while their advent is comparatively recent, are yet *indispensable*, requires emphasizing. That not only in individual instances, but whole sections or districts can be cited, wherein obstetric work is performed after the manner of thirty years ago, we all know.

It does seem that in the rapid march onward which has been made since the introduction of antiseptic measures, midwifery has been left far in the rear. How common it is to find a general practitioner, who, in the performance of his routine work in office or elsewhere, has recourse to the protection afforded by the now indispensable bichlorid comp. tablets, whether that work involves the care of an injured finger or other member, the examination of an eruption on the skin, the care of an abscess—it matters not, it is performed with an eye to surgical cleanliness. Now let that physician be called to an obstetric case. If it be a normal delivery, slow or fast, tedious, or the child be precipitated into the world, it is allowed to progress to its completion, or rather till the fetus is expelled without any interference on the doctor's part in the way of cleansing, to say nothing of shaving the vulva or making other preparation of the bed than those in attendance have already made for the reception of the infant and the protection of the mother, a necessity patent enough if only in event of laceration; and these cases are not all found in the small centers

and country practices, not by any means. It would seem unnecessary to say that such procedure is added to, by a neglect to examine the patient carefully for possible lacerations in the parturient tract. The necessity for such precaution is obvious, for the apparently natural and often rapid or precipitate deliveries produce the greater percentage of those cases, who eventually come into the surgeon's hands for perineal repair, for I do not think that any will deny that the forceps when properly used, tends to the conservation of the integrity of the pelvic flow. Again, the subsequent care given to women who are attended to after such fashion, what is it? And take the uses of anesthesia, the Balm in Gilead in every case, wherein pain is a factor, its beneficence acknowledged, its use indispensable—except in labor. Those who do make use of it, of course, cannot feel that the fact that such is their practice, is overlooked. It is by the sharp contrast between its use and the unspeakable misery, uselessly endured, by its non use that renders the latter method intolerable, and it is more than tiresome to see the subterfuges put upon defenceless women by the doctor who to hold his families in those communities blessed by one or more practitioners, who do show the same mercy to the patient in labor that they exhibit toward her husband, who may require a two-minute anesthetic while removing a thorn from his thumb or the lancing and cleansing of a boil. Who present does not know of one or more who makes a practice of promising their expectant case that, yes, they will administer chloroform, they will do all in their power to mitigate the suffering of that inevitable hour of darkness, and then when the time does come, put off and put off again, and even resort to the dishonest and unfair statement that it is dangerous, and they would, but they can't risk it, and perhaps for a brief period enact the farce of producing a partial anesthesia, and the critical hour past, endeavor to hold the respect and esteem of that outraged patient by the trifling and untruthful statement that she is not a fit subject for chloroform.

It is unnecessary to make any comparison between labor and other processes which are accompanied by pain. The need—great need—for an awakening in this respect must be apparent to all. The lack of attention to and the careless disregard of the pregnant woman's welfare is all too common. Except it be in exceptional cases of emergency work, all surgical cases are carefully prepared for operation, no slightest detail is too unimportant to be omitted and rightly so. But the act of maternity must also be regarded in the light of a surgical case, and I think all will admit, a serious condition.

To permit a pregnant woman, the conduct of whose delivery is bespoken beforehand, to approach to full term without a careful supervision of the general health and welfare of such an one, is worse than careless. This supervision embraces everything pertaining to the health and comfort of the patient, the hygiene of the person, the care of the nipples and breasts, attention to diet, regulation of bowels and the very essential watchfulness to be maintained by a sufficient number of examinations of the urine to ensure a quick discovery of a possible albuminuria. In lieu of any of these and other precautions what is the ordinary custom? When

asked to take care of a given case, enter the probable date in an obstetric note book, and when sent for, go to the confinement, generally wait for delivery and then tie the cord, collect the fee and depart.

Long is the list of topics in this department of our science that are waiting discussion and an indefinite length of time should be consumed in their enumeration, however, that part of the work which I have endeavored to express a few thoughts upon, is not of the active stage of labor, but rather upon the work left to be performed after the labor is completed. Each case of labor must, of necessity, be considered a law unto itself, yet there is a line which should mark the physician's duty, a varying line, truly yet distinct and clear. The patient herself, her home, environment, the quality and fitness of the nurse are some of the features that make necessary the just mentioned variation. When a physician undertakes the care of a pregnant woman, he or she, should acquaint him or herself with a fair knowledge of the patient's surroundings and circumstances. The time preceding the onset of labor and the experience gained during that process, acquaints one sufficiently with the help at hand, with the service which the lying-in-woman will receive, be that help merely the members of her family (by no means an uncommon circumstance), a husband, daughter, sister, friend, or a nurse regularly employed, competent or incompetent, as may be. From the sum total of the doctor's observations must the deduction be made aud upon the result of his observations must rest the duties which conscience and professional zeal and honor alike, impel him to assume. Many agencies and conditions conspire to throw the onus of this admittedly self-imposed duty upon the honest obstetrician. If we desire that the spirit of commercialism do not become the dominant principle of our life-work, if we wish to maintain in fair proportion the ideal in our beloved and honored calling, then we must be governed by the circumstances in each case we are called upon to attend, obstetrics, as in other surgical work. And inasmuch as the duties of motherhood are as essential and as holy as we know them to be, and as we try to impress this truth upon these timid, shrinking women, the mothers of families ranging anywhere from one to five or six already, and who come reluctantly enough to our office to know if perchance they are again pregnant, and if so if there is no relief; so do these women deserve better care after they have carried their burden and been delivered than they oftentimes get. A little labor and thought expended in a judicious seeking for the reason why this particular type of case seeks a certain knowledge of her condition, and then perhaps a relief for it, will reveal a somewhat startling sameness of object in the reasons averred. One of the most common is, after the general dread of labor, that they just can't bear to face the two, three, four or more months after they are up and around the house, "the dragging around feeling, more dead than alive," "feeling as if all the contents of the pelvic cavity would drop clear into the world" as they usually put it, and the "bearing down sensation whch renders keeping upon the feet a perfect torture," and many similiar expressions; the complaint of inability to eat and of nervousness of headache and backache, of loss of sleep, these and kindred complaints

are very common, and they are, I believe all traceable in large measure to the lack of proper care during the period following childbirth, and I wish to emphasize this; these patients are not criminals, nor yet would-be criminals. They belong nearly always to the honest, well-earning class of our working population, the wives of husbands who cannot afford to keep sufficient help in the house. They reside in town and country alike, and their work, multiform in character is never-ending, family cares and household duties, hard to specialize, yet all indispensable, their lives very often are unappreciated, and of their heroic endurance and their patience with pain, God and themselves alone know. It has seemed to me that the presence of this class of patients in one's office is an unspoken, unconscious appeal to us for more efficient care at that time when it is so sorely needed, and that period covers not only the traditional days, but until strength and a normal condition of health generally, is established. The public has been made alive to altered conditions in other departments, they can also be made to grasp this need, and we can have done with the unreasonable and unscientific hypothesis that because a woman does not die during confinement, and that as child-birth is a physiological process, therefore she is all right.

I have made special reference to the wives of the working world, because they are the mothers of the largest families, as a rule, and are the greatest sufferers from our present lax-system of treatment during the lying-in-period. Like all other rules this has its exceptions. There are some natures that will not brook inattention at this, or any other time, and the class too, in whom the law, said to be nature's first law, is exceeding strong. Such will look out for themselves. The leisure class also suffer less, for with money no object, ample attention is sure, but despite the exceptions the general rule prevails and leaves much to be desired.

There is a way for advancement to better methods and a general improvement is easy; but to reach all cases properly, is out of the question under existing circumstances. Were the public educated to the use of the lying-in wards or hospitals, as they have been to the benefits derived from the hospital care in other surgical cases and in general illness, then would we have an ideal state of things. Necessity has wrought this change in some of the remote sections. In the west where neighbors live miles apart it has become quite common for the expectant mother to be removed from the isolated ranch into town, there to await her labor where aid is at hand when required. Loss by death and bitter experience, not the profession, has wrought this change, as is manifest by the fact that accommodation for this class of patients in those same towns is almost wholly lacking, and many of the women fall into the hands of ignorant and unclean nurses or midwives, when they do remove temporarily to town to ensure a safe delivery. Yet that these ranchmen and farmers' wives have recourse to this precaution is a hopeful sign. It points the way to certain sure possibilities in this branch of hospital work.

And, members of this Tri-State Society, in the development and founding of lying-in-wards and maternity hospitals throughout our entire great

country, in the educating of the people to this, lies the solution of and the remedy for one of the greatest menaces to America. A danger which threatens not only America is it, but the entire civilized world; the rapidly lessening number of children born each generation, and especially is this so among those whose successive generations in our land are most needed. The reflections suggested by this problem are calculated to become more than disquieting, even though we say to ourselves that the foreign element will for a time stave off this nightmare. But I would ask you if it does not lie within the province of our day and generation to set in motion the means by which such calamitous conditions can be averted? When the cities, towns and villages, large and small, throughout the length and breadth of the United States are equipped with suitable lying-in wards or maternity hospitals, as may be best, and when the women of this nation know beyond peradventure that they can be assured of good care, that they will be surrounded by every safeguard during their parturition and convalescence, and that they will again be restored to health and strength precisely as other surgical cases are, and by no means an item to be overlooked or left unemphasized, that from an anesthetic standpoint they shall suffer no loss, that they will become again what they were before in figure, complexion (for a reasonable personal pride is inseparable from selfrespect, and as necessary to the maintenance of high moral tone as any of the other attributes that go to make up the personnel of a desirable mother). When these conditions have been established, then can we hope to have an end of the growing condition which we all deplore and fear, and speaking for my own sex, I honestly believe that the duties now shrunken from will be assumed naturally, easily, and as Almighty God proposed they should be, and until this much to be desired time shall have come, there can be given to the just delivered patient a safe conduct through her convalescence an opportunity to fit herself for the duties awaiting her brain and hands. A close watchfulness over her condition and a correction of whatsoever may need it, laceration slight or extensive, a possible subinvolution, too free blood discharge, the appearance of sepsis even after days of normal record lassitude and weakness subsequent upon the performance of too heavy work during pregnancy, sleeplessness from care of a fretful or sick baby, or any of the many irregularities that beset the pathway of these cases.

And I wish in closing to put in a good word for the adoption of a properly fitted abdominal bandage, such as can be worn comfortably for a few weeks after confinement. The sense of support and comfort it affords is very great, and aside from that its use from an anesthetic standpoint cannot be overestimated. As a preventive agent against the acquirement of a pendulous abdomen in those mothers who are obliged to keep about the house from the hour they are able to resume their usual routine the application of the bandage would be fully warranted, did it serve no other purpose.

Fevers of the Puerperal State; from the Surgeon's Standpoint.

By Emory Lanphear, M. D., Ph. D., LL. D.

ST. LOUIS.

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Read at the Chicago meeting of the Tri-State Medical Society, April 4, 1902.

PERHAPS the most deplorable fact connected with our boasted twentieth century knowledge of asepsis and antisepsis is that puerperal infections are today—outside the modern hospitals—practically as common as they were in preantiseptic days! In lying-in hospitals where the parturient woman is considered a wounded woman, and treated with the same attention to surgical cleanliness as if the peritoneum were being opened; where surgical principles are rigidly applied to obstetric work, the mortality from "child-bed fever" has been reduced to zero; and from these institutions we have learned the important truths:

(a) That the temperature of the woman properly confined should never rise above 99 deg. F.

(b) That the old idea that there must be a "milk fever" is erroneous; normal labor and normal puerperium are attended by normal temperature.

(c) That any deviation from this rule means septic infection of some kind—generally the fault of the attendant, and therefore preventable.

But while the mortality has dropped to practically zero in institutional work, in country practice and in the work of city men not perfectly familiar with the aseptic technic fevers of the puerperal state are fully as abundant as of yore, and in the practice of midwives the fatalities are truly appalling.

CAUSES OF HIGH MORTALITY.

The terrible mortality may be ascribed to several things:

I. Non-familiarity with the various causes.

II. Inappreciation of the term asepsis.

III. Gross carelessness.

IV. Meddlesome interference with a natural process.

V. Spread of venereal diseases.

I. The time is gone when any physician who makes any pretense of being "up with the times" can be content to say: "This patient has puerperal fever" or "'that woman has puerperal sepsis," or "the other patient has puerperal peritonitis"—these are all terms of the days when we were just emerging from the darkness of the older pathology. He must be more definite—not especially that he may make a correct clinical diagnosis, but because the intensity of the attack and the prognosis depend upon the character of the poison producing the fever; nay, more: the very selection of the proper treatment, surgical as well as medicinal, must be based upon an exact knowledge of the pathological condition present as well as the causation thereof. It is true that in some instances differential diagnosis is, as yet, impossible, but in a large majority of cases it is possible to

clearly determine the precise cause, and intelligently apply proper measures.

Thorough comprehension of the general subject of acute septic infections of the genital tract, puerperal or otherwise, involves a study of practically all of the pyogenic bacteria, a special knowledge of the natural history of each variety of fungus implicated, and finally a critical analysis of the clinical phenomena each may produce.

At the outset several important facts may be formulated and made prominent:

1. The normal vulva constantly contains myriads of bacteria, pathogenic as well as innocent, which may be easily introduced into wounds of the genital tract by careless methods.

2. The normal vagina of the pregnant woman does not contain any of the pyogenic micro-organisms, hence "autoinfection" of the pelvic organs is not a possibility in natural labor.

3. The vagina contains innumerable forms of non-infective bacteria normally, but these disappear at the cervix, no microbes ever being found in the cavity of the uterus under natural conditions.

4 The secretions of the cervix uteri, as well—in less degree—as those of the vagina possess mild antiseptic power, so that unless an unusually large number of virulent organisms be introduced no severe infection is apt to occur.

VARIETIES.

1. Saprophytic infection.
2. Streptococcus infection.
3. Bacillus coli communis infection.
4. Staphylococcus infection.
5. Gonococcus infection.
6. Pfeiffer bacillus infection.
7. Klebs-Loeffler bacillus infection.
8. Infection with vibrion septique (Pasteur).
9. Pneumococcus infection.
10. Mixed infection.

1. SAPROPHYTIC INFECTION ("SAPREMIA").

The most common, the most dangerous and the most easily cured infection of the lying-in period is saprophytic in origin. The vagina of the average woman contains saprophytes—the germs of decomposition—which no amount of preliminary douching will destroy. Under common conditions these germs are non-pathogenic, but when a piece of placenta is left behind, when large blood-clots remain in the uterus, or when the drainage of even the natural discharge of blood from the uterus is interfered with putrefaction begins. Frequently the uterus is able to expel the foul, infected, stinking mass and the worst that then happens is an offensive lochial discharge with a slight rise of temperature. In other instances Nature is not able to care for the patient, and an illness of intense degree arises. The clinical history and proper treatment of this form of puerperal infection may be told in the following case history:

Mrs. A., patient of Dr. W. M. Dunn, aged 30, in her second confinement, was perfectly comfortable until thirty-six hours after the fetus was expelled, when she had a slight elevation of temperature; a few hours later there was a sharp chill followed by a temperature of 106. She was admitted to the Woman's Hospital with distended abdomen, putrid discharge from the vagina, temperature 106, but skin cold and "clammy," slight delirium, heart intermittent and weak. Examination showed the os well dilated, but a fragment of placenta and some remains of the membranes hanging in the cervix (Dr. Dunn had not been in attendance until a few hours before her admission to the hospital, and therefore was not responsible for her condition—the accoucheur being a "professor" in a St. Louis college). Removal of the putrescent mass with copious irrigations of mildly carbolized hot water immediately relieved the condition and restored the woman to a practically normal puerperium. In this instance it was possible to remove the offensive material with the fingers and a strong current of hot water.

When one is called to a case of "puerperal sepsis" the first point to be determined is whether the condition is sapremia or septicemia—to use the phraseology of yesterday. It being decided that it is a fever due to saprophytic infection, i. e., bacteria of decomposition working in retained debris, there is but one thing to do—clean out the uterus and vagina thoroughly, and at once. From the always well-dilated or the stinking putrid mass may be removed by the fingers or a dull curette or spoon with irrigation—the sharp curette means death!

For irrigation formalin solution, one-half of one per cent, will be found cheap and effective. When the patient is not treated at all, or is improperly managed, the disease progresses rapidly until death closes the scene.

Mrs. R., patient of Dr. H. G. Nicks, was admitted to the Woman's Hospital December 9, 1901, suffering from puerperal sapremia. She had been delivered by an eminent practitioner of St. Louis, who unfortunately left some placental fragments and membrane in the uterus. Saprophytic infection promptly followed and he, mistaking the indications for treatment, instead of removing the putrifying mass with a spoon or large dull curette, chloroformed the woman and "scraped out" the uterus with a sharp curette. While the decomposing material was greatly diminished by this procedure, there was a great outpouring of blood which in turn became retained and infected with the bacteria of putrefaction. The fever, therefore continued at 105, delirium ensued, diarrhea followed, the skin became cold and clammy, and Dr. Nicks was called. But it was too late—the venous sinuses reopened by the use of an improper instrument allowed the system to become overwhelmed with the saprophytic poison and she died in profound coma, the temperature record showing a trifle less than 108 deg F. Here was a life sacrificed by the fact that a busy practitioner did not recognize saprophytic infection and treat it according to surgical principles.

Packing the uterus in such cases is improper—a simple gauze drain through the os being sufficient. In ordinary cases repetition of the irri-

gation is not advisable—the possibility of engrafting a streptoocccus or staphylococcus infection upon the already injured part is a greater danger than leaving some decaying matter behind. On account of this menace to life the utmost care must be maintained during operative procedures—as strict asepsis must be maintained as for any other operation; the simple existence of a stinking discharge is no excuse for dirty surgical procedures. If the temperature again rises above 102 or 103 after the fall, which always follows emptying and irrigating the uterus and vagina an intrauterine douche is advisable. A second curettage is rarely permissible, especially if the first has been perfect, unless a secondary infection with pyogenic organisms occurs.

2. STREPTOCOCCUS INFECTION.

Next to puerperal sapremia streptococic infection is the most frequent of the septic fevers with which parturient women become affected. Germs of erysipelas are everywhere; notably under the finger-nails of doctors! The physician who attends scarlet fever, erysipelas, carbuncle and other infective diseases in which the streptococcus plays an important, if not a causative role, is almost certain to infect his patients if he attend confinements without taking the most extraordinary precautions as to hand disinfection. This fact was indeed known, clinically, long before we had any knowledge of the streptococcus; as was also the fact that dissection of dead bodies by an obstetrician would cause "child-bed fever" before we learned that saprophytes are the cause of decomposition—as well as the most virulent form of puerperal infection.

Streptococcus infection generally occurs through a wound of the perineum or the lacerated cervix, occasionally through the uterine tissues primarily. As this germ is one which does not readily give rise to extensive suppuration we can readily understand how it happens to result in huge inflammatory exudates in the pelvis—the uterus, tubes and ovaries often becoming welded into a solid mass from the pelvic peritonitis and pelvic cellulitis—without the formation of an abscess in either the tubes or the cellular tissues. Later on if "resolution" does not occur, and particularly if a mixed infection (with staphylococci or bacilli coli communis) arise pus may form either as pyosalpinx or abscess of the broad ligament. The various manifestations of streptococcus infection as well as their management are best told in the following case histories:

L. J., patient of Dr. Geo. Howard Thompson, was delivered at the Woman's Hospital. There was complete laceration of the perineum necessitating immediate suturing. By imperfect preparation on my part, or by reason of the rectal tear streptococcic infection occurred. On the fifth day there was a slight rigor with a succeeding temperature of 101½, with much pain at the line of sutures. Examination of the wound showed a mild, erysipelatous blush which next day presented the characteristic appearance of erysipelas as seen elsewhere in the body. As there was no evidence of pelvic complications, and the temperature did not go above 104, the uterus was not examined nor treated. Bichloride douches (1 to 1000) of the ostium vaginae and external application of carbolic gauze (1 to 20) constituted the sole treatment, under which the disease ran a mild course

and terminated favorably by the end of the fifteenth day. The uterine and vaginal discharges were, in this case, able to take care of the internal genital organs, so that the woman is now in excellent health save for a perineum imperfectly united.

Here was a case in which active surgical treatment would have resulted disastrously. Had intrauterine medication or curettage been attempted there is no doubt that acute pelvic peritonitis would have followed, possibly fatal. The good result came from judicious noninterference. It typically represents the mildest type of streptococcus infection — one in which the fever depends entirely upon the local infection of a wounded surface. Unfortunately such slight attacks are rare, and limited to perineal infections. When the streptococci have been introduced directly into the uterine tissues through (a) a lacerated cervix, or (b) the wounded endometrium there is quickly set up a metritis and pelvic peritonitis.

Mrs. P. L., patient of Dr. J. C. Sullivan, was delivered by midwife. Everything seemed to go well until the seventh day when a severe chill occurred, followed by temperature of 103½. Next day another chill was succeeded by a fever of 104½, and the next day the register was 105. On the fifth day of the fever the doctor made vaginal examination and found the uterus fixed in a mass of exudate. Rightly divining that curettage would be worse than useless, and that the only hope of receiving a favorable termination lay in supportive treatment and local measures calculated to cause absorption of the exudate Dr. Sullivan used quinine and strychnine internally and hot douches thrice daily with glycerine and ichthyol tampons at night. Gradually the fever subsided and a slow convalescence seemed established when a hard chill and acute fever, followed by sweating, foul tongue, mawkish breath and other evidences of sepsis showed that pus had formed and needed operative measures. On admission to the hospital at the end of her sixth week the pelvis was found completely filled with exudate, the uterus was immovable, deep fluctuation could be detected in each broad ligament and pyosalpinx was suspected in addition to the abscesses of the connective tissue around the uterus. The os was gently dilated and the uterus irrigated with lysol solution; the abscess cavities were opened and the thin, ichorous pus allowed to escape; the pus-pockets were gently curetted and packed with iodoform gauze. Three weeks later the general condition having greatly improved the two suppurating tubes and the infected uterus were removed by abdominal section, and the patient made a slow but perfect recovery.

Here was a case in which, had a bacteriological examination of the uterine discharge revealed nothing but a pure streptococcus infection at the time of highest fever, Marmorek's antistreptococcus serum might possibly have been of benefit; but I must confess that thus far I have been disappointed in its use in streptococcus septicemia. Intravenous injection of normal saline solution proves beneficial in a small percentage of cases. The chief indications, however, are supportive measures of the strongest kind (whiskey, strychnine, food, etc.), non-interference with the endometrium, local antiseptic treatment (douches and tampons) and opening of pus-pockets as soon as they can be detected, either above or below.

Mrs. C., patient of Dr. J. T. Walsh, developed fever on the ninth day after confinement, the temperature and progress being much the same as in the preceding case up to the period of pus formation. Instead of an abscess developing there was gradual absorption of the pelvic exudate, but a year later the woman was still in ill-health, and pelvic examination shows both tubes and ovaries fixed at the bottom of Douglas' cul-de-sac, chronically inflamed, tender, enlarged; the patient a semi-invalid; perpetual sterility and ill-health before her, unless she submit to pelvic section for relief.

These are the cases which fill our hospitals and sanitaria, and which give such brilliant surgical results so far as mortality is concerned—often dubious enough so far as the happiness of the patient is involved if she be true woman with the mother-instinct.

3. BACILLUS COLI COMMUNIS INFECTION.

This microbe inhabits the large intestine and plays an important part in the production of appendicitis, suppuration of ovarian cysts, etc. The proximity of the anus to the vagina renders contamination of perineal wounds and lochial discharges very easy.

Two hours after her delivery I was called to sew the perineum of a primipara in previous good health. The tear extended to the anal margin. There was also an extensive tear of the left side of the cervix, which I did not attempt to repair. She had been attended by a competent man who had used every necessary antiseptic precaution. But in transferring her from the table to her bed her bowels moved, and by a semi-conscious movement of her hand the patient smeared wound and vulva with fecal matter. The greatest care was used to again disinfect the parts, but an acute inflammation with intense suffering necessitated removal of the sutures on the fifth day. The cervical wound became infected and a thin purulent discharge followed. At no time did the body of the uterus become implicated in the inflammatory process, nor did the temperature of the patient ever arise above 101½; but an abscess formed to the left of the uterus, in the loose connective tissue, which had to be widely opened and loosely packed with gauze. Bacteriological examination of this pus as well as the discharge from the cervix showed colon bacilli and a few undifferentiated staphylococci; that from the perineal wound gave bacillus coli communis predominating, with staphylococcus epidermidis albus in large numbers also.

Many of the mild puerperal fevers, hitherto regarded as light septicemia, will in future, I believe, be classed as bacillus coli communis infections.

4. STAPHYLOCOCCUS INFECTION.

When it is remembered that the various forms of staphylococcus are found everywhere in air and dust, on all cutaneous and most mucous surfaces it is astonishing that infection with this germ is not more common in the puerperal state. That its tendency is to produce purely a local suppuration (the staphylococcus pyogenes aureus being the particular

germ of the "laudable pus" of our medical ancestors) rather than general infection is the probable explanation. When general infection with it does take place the course is about as follows:

Mrs. B., patient of Dr. W. H. Townsend, was confined with her first child without chloroform or forceps; labor normal with slight tear of perineum. She had a suppurating sore of the finger, and in spite of the doctor's warning would change her gauze pads. On the third day there was a slight chill, with temperature of 102 following, and a few days later suppuration of the perineal wound was noted. The fever continuing an eminent teacher of obstetrics was called and although the uterus was not fixed nor greatly enlarged, nor tender, on account of the continued fever (100 at morning and 101 at night) he curetted, without obtaining anything except blood. There was a chill soon after, followed by much pain in and above the uterus. Three weeks later an abscess could be made out to the left of the mid line above Poupart's ligament. Under chloroform I opened this and evacuated a quart or more of staphylococcus pus, gently curetted the abscess walls and stuffed with gauze. Good and speedy recovery has followed. Examination of the pelvis under anesthesia showed the uterus to be freely movable and no larger than natural at the time after labor.

Here was a case in which the folly of curettage of the uterus in some forms of "puerperal fever" is apparent. The temptation to "do something"(for a fee?) in the way of operation should be resisted to the limit of simply following the plain indications only.

5. GONOCOCCUS INFECTION.

In cities where gonorrhea is so common, puerperal infection dependent upon Neisser's coccus is, in my opinion, next in frequency to that caused by the streptococcus; and it is far more common in country practice than generally believed.

The symptoms are not so acute as in sapremia or streptococcic septicemia, but are sufficiently severe to be alarming. The course of the disease does not differ materially from gonorrheal pelvic peritonitis in the non-puerperal woman except in the intensity of the initial chill and fever.

I. C., patient of Dr. G. H. Thompson, contracted a gonorrhea some weeks before an abortion. Three days after abortion (induced by a female doctor) chill, fever and abdominal tenderness developed. Next day Dr. Thompson found temperature 101, pelvic peritonitis developing, uterus enlarged and tender. Curettage and drainage did not improve her condition, so she was admitted to the Woman's Hospital. For three weeks the peritonitis ran a mild course under the use of salol and codeine, with mild laxatives, and douches of hot water thrice daily; the temperature gradually dropping from 101 to 99. Then a sudden chill and a rise of fever to 104½ with intense abdominal pain seemed to call for immediate abdominal section On opening the abdomen it was found that an acute gonorrheal pyosalpinx had ruptured and general peritonitis resulted. The abscesses were removed and the pelvis cleaned and drained, but death from acute sepsis followed in thirty-six hours.

This is the typical history of this form of infection—up to the time of rupture of the pus tubes. Usually the patient lapses into chronic invalidism until she falls into the hands of a surgeon who recognizes the condition, and either kills or cures, according to his particular skill. Most of the patients recover perfect health after thorough operation.

6. PFEIFFER BACILLUS INFECTION.

When we consider the general prevalence of lagrippe and the now well-known tendency of the Pfeiffer bacillus to produce pus under favorable circumstances we may well be surprised at the probable infrequency of puerperal infections due to this microbe.

Mrs. S., known to be suffering from la grippe at the time of her expected confinement was admitted to the Woman's Hospital for accouchment. On account of her bad condition every possible precaution was taken—she was confined on a glass table in the surgical operating room, under chloroform anesthesia, with forceps, with the same care given to abdominal section patients; but of course on account of the necessity of frequent changes of the bichloride dressings over the vulva there was more or less exposure of the perineum which was lacerated to the extent that four sutures were needed. Everything went well until the seventh day when the nurse reported the perineal wound "irritated." Examination showed it to be infected in some manner—there was a thin, irritating pus around each of the stitches. On the ninth day (the general grippal symptoms having all disappeared and the friends expecting the woman to sit up next day) there was an unexpected rigor, the temperature shot up to 107½ and dissolution seemed imminent. Within two hours she was anesthetized and the uterus dilated and curetted, as the high temperature seemed to indicate delayed sapremia; nothing being found except the same thin, pale pus which covered the perineum. The perineal sutures were cut and the wound (which showed no tendency to unite) allowed to gape. Examination of the pus from both perineum and uterus showed nothing but pure Pfeiffer bacilli present. Next day the temperature dropped to 96½ and again rose to 107, when 10 grains of acetanilid with one ounce of whisky were given. Antiseptic douches were given every six hours, with intrauterine douches once daily, and large quantities of strychnine and milk punch by the stomach. For six days the temperature varied from 97 to 106, and then gradual convalescence occurred; with full restoration to health. At no time was there any uterine fixation or tenderness, tubal enlargement or sign of peritonitis.

The remaining three distinct forms of puerperal sepsis are so rare that I pass them without special reference. I have seen but one case of pure Klebs-Loeffler bacillus infection in a perineal wound; and neither of the other two. Mixed infection is very common, especially staphylococcus with streptococcus, and streptococcus or staphylococcus with gonococcus. It simply adds seriousness to the situation, and calls for more care to prevent their occurrence in dealing with any form of puerperal infection.

CONCLUSION.

In conclusion, I wish to state emphatically that "puerperal fevers" will practically disappear when doctors and midwives learn that:

The woman in labor and immediately after should be treated upon the same rules of antisepsis as govern the surgeon in the most extensive operation.

DISCUSSION OF DR. FLORENCE PATRICK'S AND DR. EMORY LANPHEAR'S PAPERS.

Dr. Emil Ries (Chicago): The paper of Dr. Patrick I think should not go without a word of praise, containing, as it does, so many good suggestions, which I am afraid will only become thoroughly useful when there is a penalty imposed on forgetting. We have given these suggestions for ages—as suggestions, as advice, and, in some states and countries they have been made laws, and are sinned against every day. I wish the paper could have a wide distribution and be read as carefully as it deserves.

Regarding Dr. Lanphear's paper, he uses the phrase, "In the language of yesterday," speaking of the distinction between saprophytes and other germs. I am sorry to say that Dr. Lanphear's paper is in the language of yesterday, not only in respect to bacteriology, but in respect to the treatment of septic uteri—not all the treatment, of course. I refer especially to the famous dull curette; I refer to the intrauterine douche, and I refer to the rules brought out to support the doctor's advice. The theories are of yesterday and the treatment is of yesterday. There was a time when we did not know anything about this curettement, and when it was first brought out it carried the world, especially as it came supported by a very exact authority. Reports concerning it were received from good men, and apparently the treatment was well supported. The treatment has been in existence for probably some twenty years, and the advanced and better obstetricians are about beyond it. The use of the dull curette has been relegated to the antiquated methods. The use of the intrauterine douche is counted among the dangerous procedures, and the whole theory of the treatment is exploded. I have not done the exploding nor the relegating. I am one who follows; but I can tell you of some personal experiences. I had the good fortune to be an assistant in a hospital where we had some two hundred septic cases a year. It had a special pavilion for septic cases and all doctors who sent their patients away, sent them there, and they were very glad to send their septic cases away.

We started in with the treatment much on the lines of the dull curette, the intrauterine douche was given every six or every twelve hours, we employed continual irrigation with antiseptic solutions, with normal salt solutions we operated extensively. Of course, what Dr. Lanphear said about opening up abscesses is absolutely correct; there is no discussion on that point at all, but I am speaking of the septic endometrium and the removal, not only of this, but the removal of the whole uterus. The results were just the same. If you have a case of typhoid fever with an infection of the bowel by the typhoid germs, and you scrape every typhoid ulcer in the bowel, have you cured the typhoid fever? If you have a case of diphtheria and you scrape out the throat and remove the membrane, scrape

the tonsils, apparently all traces of the disease away, have you cured the diphtheria? You all remember that when we did not have the antitoxin, we pulled away the membrane from the tonsils, put antiseptic solutions on them and in the throat, and when it spread out we did everything we could to remove the disease; did we cure the cases? In a case of pneumonia with infection by the pneumococcus, give any drug to that patient, let him inhale any antiseptic solution that you like, but does it cure the pneumonia? That is where the difficulty is. You can put as many antiseptic solutions as you like on the surface of the human mucous membranes; underneath the germs grow lustily in spite of all. We have been advised to use the dull curette as it does not do so much harm. With the dull curette we take away nothing but the dead tissue and the sepsis is beyond that. If you take the sharp curette, you don't even take it away then. Why not? If I make a very small sketch, I can make it plain in a minute.

Here is the surface, the endometrium, on top of it the dead, sloughing tissue. The infection migrates along the lymphatics down here into the interstices between the muscle bundles and goes on into the uterus along the blood vessels, into the broad ligaments to the nearest lymphatics, and so on, and if you take out the whole uterus you have not all the sepsis. One man, a good surgeon, a very thorough man who knew his pathology, went further. This sketch shows the uterus, tubes, ovaries, the vagina, the lymphatics starting from them and going into the lumbar glands along the spermatic vessels. The surgeon was not satisfied with the taking out of all these organs, but removed also the broad ligaments and lymphatics away up. The patients died just the same.

When you have a septic infection you cannot remove the sepsis by an operation, unless you remove everything that is infected, and that means more than we can do—more than is now within the domain of surgery.

I treat my septic cases very little. I don't curette, I don't use intrauterine douches, I don't take out the uterus in the acute stage, and I don't go in with my fingers and manipulate the uterus and force infection into the lymphatics. I treat exactly as for typhoid fever. I will go in there if there is hemorrhage; I go in and take out the remnants of placenta and pack, and I know every time I do that, that there is a risk of the patient having her first chill directly afterwards. If I can avoid going into the uterus at all I will avoid it every time.

Dr. C. E. Paddock: We have clinical evidence in cases coming to us with high temperature, rapid pulse and every indication of infection. We explore the uterine cavity, find particles of retained placenta, or membranes, or blood clots, and after removing the same by the finger or by the intrauterine douche the temperature and pulse almost immediately return to the normal. We have cases coming to us with retention of a large part of the placenta which we remove. Now does Dr. Ries mean to say that he would leave the removal of such retained particles as these to Nature?

Dr. Gustav Futterer (Chicago): I do not care to say anything about the modes of infection of the uterus, as that has been so well covered by

Dr. Lanphear. I do, however, wish to recommend the use of oil of wintergreen, a two minim capsule every two hours until five or six doses have been taken daily. If the patient objects to taking the oil by mouth, it may be given by the rectum by mixing a teaspoonful of the oil with four tablespoonfuls of cool milk. This should be injected into the rectum every two hours from four to six times a day. An energetic, but well directed use of Merck's or Fisher's oil of wintergreen in all septic conditions, will be found of great benefit.

Dr. Fenton B. Turck (Chicago): I wish to say a few words in reference to the two papers that were given here this afternoon, the first dealing with treatment after parturition and the other with the accidents of infection. In the conditions described in Dr. Lanphear's paper, the expectant plan of treatment is now generally adopted. In the first paper where we have a description of normal labor, the after-treatment is a subject that is particularly interesting, because so much can be accomplished and so many ill after-effects avoided by a little care. From the fact that I see a great many cases showing the results of improper care after parturition, I am interested in this class of cases. Landau calls attention to the fact that a large proportion of cases of gastroptosis and enteroptosis are the direct results of lax abdominal walls following parturition. He calls attention to the folly of letting the abdomen go without a bandage and the lack of care given these cases, and makes the sweeping assertion that all cases of enteroptosis are the result of lax abdominal walls. Other observers acknowledge this as an important etiological factor, but not the only one. Another important one is defective development. Following Dr. Patrick's remarks, it might be well to call attention to one or to methods for the prevention of bad effects following parturition. I shall discuss a little the therapeutics indicated in these cases.

The arterial bandage does not increase arterial pressure, relieves the vascular system, but does not cause hypertrophy of the abdominal muscles. I have found that an extension system of exercises is of almost inestimable value in these cases, and should be generally adopted. Extension movements can be made that will wall into use the abdominal muscles and may be practiced several times a day without fatigue, and I have devised a little arrangement that can be used in bed. I call it my H exerciser. This apparatus consists of two double cords stretched from the head of the bed to the foot, running parallel to each other, from two and a half to three feet apart, a horizontal bar being placed at about the distance of the extended arms. Hence the name, "H" exerciser. The double cords are so attached to the bar that this may silde up and down with friction resistance. The extended arms, grasping the horizontal bar, push it forward and withdraw it, in a motion similar to turning a grindstone. The arms and legs should not be flexed, but kept rigid, thus throwing the work upon the body. As the body is bent forward and downward, there is resistance from the cords above and below, and as the circle is completed in coming backward and upward, there is again resistance, but in the opposite direction. A period of rest occurs when the cycle is complete, giving ample time for equalization of the circulation. In the beginning, a

pause of about two minutes should follow after five cycles, the number of which are to be increased day after day until twenty-five cycles are made between rest periods. The physician should regulate the amount of exercise according to indications. These exercises can be begun by the parturient woman after the third day, from a few minutes in the beginning and gradually increasing, repeating the exercises two or three times a day.

Dr. Campbell (Chicago): The paper read by Dr. Patrick is commendable. The general technique of obstetrical practices is not too well understood. There are a few points in Dr. Lanphear's paper that I wish to consider. He furnished us with a report of a case following child-birth which had been curetted with a sharp curette, which terminated fatally, ascribing the death to the sharp curette. I am of the opinion that it is not so much the curette as the method of using it. I had thought the profession were pretty well agreed as to when curette, and as to the best kind of instrument to use. I believe less harm is done with the sharp curette than with the dull one. Dr. Ries has given us a report from the German hospitals in which he claims that all of the usual methods of treatment, as mentioned by Dr. Lanphear have been tried and discarded in the treatment of infection following labor. Have the Germans offered us any better treatment? or have they lowered the mortality in this class of cases by the do nothing treatment as advocated by Dr. Ries? I believe my own clinical experience justifies me in the use of the curette for the removal of retained portions of placenta, especially where there is evidence of saprophytic infection.

Dr. C. H. Andersen (Chicago): This discussion reminds me of the time I was going to Asheville and we were switched off. I wish to compliment Dr. Lanphear on his paper, and I wish to speak of those cases that died. I believe as Dr. Ries does, that if the patient has a high temperature, the infection has gone beyond the uterus, and I believe in treating not the cause but the effect. What does the patient die of? She dies of infection of the blood. I believe that every one of those cases should be bled, and they should be transfused with hot, normal, saline solution. It cures some of these cases—at least 1 per cent are cured. The patients die of toxicity of the blood, and if one pint of this blood is removed and the patient is injected with hot salt solution, the heat stimulates the central nervous system, stimulates secretion of the kidneys, throws off other toxic elements, and there is a general thinning of the toxic material by the salt solution. I have seen in Dr. Ferguson's clinics many such cases, and we have cured a few of them. It is a valuable way to treat these cases that are going to die, and it seems to me that it is a very practical thing to do.

Dr. H. A. Leipziger (Burlington, Ia.): It is interesting to note from this discussion, and also from the feeling of the profession in general that it seems preferable nowadays to take a parturient woman to a hospital. I think it was late in the 70s that the Semmelweis method of using chlorinated water as an antiseptic was introduced into the Vienna lying-in hos-

pital, and changed a veritable slaughter house of death by puerperal sepsis into a harbor of safety. Garrigues read his paper on antiseptic midwifery in 1883, and at that time introduced the treatment into the Maternity Hospital of New York. I was interne at that time and had the pleasure of carrying out Dr. Garrigues's treatment. In September, out of fifty women in the ward, ten had puerperal sepsis. On October 1, he introduced antiseptic treatment, and the result was that for six months following there was not alone no fatality, but scarcely any morbidity in the hospital referable to sepsis. At that time I remember that at the Academy of Medicine of New York, it was stated that the country doctors said they never seen puerperal sepsis—that it did not exist outside of the city hospitals; and now we look for our puerperal sepsis cases outside of the hospitals in country towns and homes.

I think the impression has gone out from Dr. Ries' remarks that he would not go into the uterus for anything excepting hemorrhage. I think that it would be unwise if this were given out as advice to men in the beginning of treatment in a septic case. A man who is called to a case where he suspects that there is a piece of placenta remaining in the uterus, would act unwisely or dangerously if he were constrained by such advice to leave that alone. Certainly quality as well as quantity cuts some figure, and if you cannot remove all the foci of infection by curetting, it must be of decided advantage to remove as much as possible of the material that gives rise to that poison. If we could qualify our cases, as Dr. Lanphear has stated, then we should know how to treat them, but coming across them as we do, it must be admitted that the home obstetrician and the general practitioner must, if not with his fingers, then with the dull curette, or some other instrument, remove the material that produces sepsis.

Dr. J. C. Murphy (St. Louis): I was a little amazed at the statement of Dr. Ries that he would not go into the uterus for but one cause, and that cause hemorrhage. Any one who has had a dozen cases in the whole course of his career, has seen what beautiful results were obtained from curettage. We have heard a little about the eight or ten kinds of bacteriological infection, but I am willing to bet $50 to 5 cents that there are not 15 per cent of the general profession in this country who could tell a piece of infected tissue from a piece of wall paper, under the microscope; they "all look alike to them." They know that their patient had a baby a week before, and now has had a chill and a temperature, and that there is an offensive discharge from the uterus. The practitioner's main object is to get rid of it. It is not possible that a man of Dr. Ries' undoubted ability would say that it is the wrong thing to try to clean out a uterus that he finds in that condition. He did not mean that, but a good many people will take him literally.

Regarding the use of the dull curette, I would as soon try to shave with a dull razor as to curette a uterus with a dull curette. But it is the man behind the curette, as it is the man behind the gun, who, if he knows his business can go into the uterus with the sharp curette, and he won't

go too far. It is very doubtful if we have an antiseptic that will be powerful enough to overcome infection that has gone into the blood, and it seems to me to leave the infected uterus entirely alone is like having a break in the water-pipe in the other room and standing in this room with a mop and attempting to take up the water with that as it flows in, when, if we went back and repaired the pipe, the overflow would cease. There are so many undoubted evidences that we do get rid of infection by taking it at its site, that it seems to me almost criminal if a doctor has a puerperal infection, for him to leave the uterus alone. I don't believe in intrauterine douches, because if there is a local infection, by pouring large quantities of antiseptic solution over it we are liable to wash the infection up into the tubes and then somebody will have to operate for pus tubes, sooner or later. The curette has a certain field of usefulness, and when the right man has hold of it, he can do a great deal of good. We would not give a shot-gun to a four-year-old boy, and we would not give the sharp curette to a man who has had no experience with its use in the treatment of cases of puerperal sepsis.

Dr. Florence Patrick: I wish to thank you, gentlemen, for the discussion and criticism of my subject. It is gratifying to know that the objections made are not that the radical change suggested is not necessary, but that the question is a hackneyed one and the change impracticable. The general opinion as expressed by this convention in the discussion of papers kindred to mine, is that the objectionable and undesirable accompaniments and sequelae of pregnancy and parturition occur outside of the maternity hospitals, in those sections where hospitals facilities are impossible. Therefore can we deduce that such hospitals are a necessity and a possibility, and I think that the gradual education of the people to the necessity of lying-in hospitals, is inevitable, and sooner or later must prevail.

Dr. Emory Lanphear: In reply to my good friend, Dr. Ries, I am sure he was thinking of my words of praise and my recommendation that the society elect him to its presidency very soon, as a tribute to his good work for the society, as well as for our profession at large, instead of listening to my remarks on the treatment of puerperal infections of various types. Those who closely followed my paper will recall the fact—which I presumed indeed, would meet with opposition on the part of some—that I advised against the use of the curette or intrauterine medication in every variety of infection excepting that single form dependent upon retention of decaying material in the uterus (so-called sapremia; better, saprophytic infection) and for this condition I recommended the use of fingers, a large Volkmann's spoon, or a dull curette—anything to remove the decomposing, putrid mass without injury to the endometrium. Just as earnestly as does Dr. Ries, I condemn the ordinary "curetting." Curetting may be proper treatment for some forms of chronic endometritis, but in acute infections it is worse than useless, and so I said, "the sharp curette often means death." Personally, I do not like a dull curette; I never use one. A large Volkmann's spoon removes the debris far better,

but it must be used with care, as its sharp edge may easily wound the endometrium. There is nothing wrong with the endometrium in these cases of saprophytic infection; the indications are to remove the decaying matter from the uterus by the most convenient means, with irrigation to assist in getting the fragments out. Dr. Ries surely does not, cannot oppose such a practice! If he were called to see a woman on the third or fourth day after confinement and found her with a temperature of 105 or 106, and a nasty, stinking discharge from the uterus, and on examination by vagina found a lot of putrid placenta, or decomposing blood-clot, or membranes protruding through the os, does he mean to have us infer that he would not gently dilate the cervix and remove the decomposing stuff from the womb? Surely not. And after so doing, or while doing it, would he not use an irrigator to wash out the debris? If not, he will lose a large proportion of his cases of saprophytic infection, as Nature unaided is not capable of caring for many of these patients. I do not advise an "intrauterine douche;" I said that 'if'—which must be rare—'conditions are such that the attendant feels that an intrauterine, or even a vaginal douche must be again employed, he must give it himself—never trust it to a nurse. The danger of engrafting a streptococcus or staphylococcus infection upon an already injured membrane, is far greater than leaving a little decaying material in the uterus.' Hence, intrauterine irrigation should not be practiced except in extreme cases, and never by a nurse or an assistant.

So much for saprophytic infection. Relative to the curette in puerperal sepsis due to the streptococcus, bacillus coli communis, staphylococcus, gonococcus and other forms in which pelvic peritonitis or pelvic cellulitis play an important part, I said that in almost every instance the curette is worse than useless; the infection has passed beyond the uterus long before the symptoms become alarming. Experience taught many of us this long ago—we didn't have to go to Germany to learn it. So too of hysterectomy. It is only in the rarest of cases, where the uterine wall is filled with multiple abscesses and the patient has passed the dangers of acute sepsis, that removal of the uterus is justifiable. I have long ago abandoned hysterectomy in the acute cases, save for one class: When the pelvis is filled with pus and the uterus is in the way of perfect drainage, it may be removed merely as a matter of convenience in hastening the operation and securing better drainage; not with the idea of curing by the operation alone.

On the whole, I am convinced that when Dr. Ries reads my paper he will agree with practically all my points. I know the pathological portions are in part new to medical literature. The treatment in each variety is that which I have found best adapted to each, based upon a consultation practice in a city where unfortunately such cases do much abound.

I am glad Dr. Futterer has called attention to the remedies from the internal use of which benefit may be expected. The medical side of these cases is too much neglected by the surgeon; thus, on the other hand, the average general practitioner is apt to rely too much upon internal medication and to lose valuable time in the use of quinine and opium instead of resorting to prompt and proper surgical measures. And this is especially

true of saprophytic infection. In the slower forms of sepsis the measures advocated by Dr. Futterer are certainly worthy of trial.

As to the assertion of our President, that most doctors are not capable of making a differential diagnosis with the microscope, I will say: First, it is possible for any doctor to distinguish between saprophytic infection and sepsis, without bacteriological knowledge, and that is the first and chief point in diagnosis. Second, there are many members of the Tri-State Medical Society who do know enough of practical bacteriology to make the diagnosis I mention, and, the time will soon come when every doctor must have this knowledge, or be relegated to obscurity in his profession.

Dr. Emil Ries: Dr. Paddock has asked me a question. He wants to know if I would not go into the uterus in a puerperal sepsis case, if the whole placenta was left. I should not regard such a case as one of puerperal sepsis; the woman is in the third stage of labor. Suppose that we had a case in which a large piece of placenta was left in the uterus and the woman had a fever. Do I take it out, or not? Is anybody going to tell me that a large piece of placenta can be left in the uterus and we have no hemorrhage? I have never seen a case where hemorrhage did not result from such a condition. I have stated that where there is a piece of placenta, I stop the hemorrhage by removal of the placenta. If I am called to a case where I suspect that there may be a little piece of the placenta left, but there is no hemorrhage, I leave that little piece alone as long as there is no hemorrhage. I wish to repeat that in a case where there is a hemorrhage from the uterus of a puerperal woman with sepsis, I stop the hemorrhage by cleansing out the uterus. If there is no hemorrhage, but there is a fever, I don't touch the uterus at all.

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Cerebro-Spinal Meningitis.—Williams, (Amer. Pract. and News) says this disease is a specific infection, slightly contagious. Whether it assumes the sporadic or epidemic type depends on climatic conditions. Unsanitary conditions and excessive exertion favor its development. It is more frequent in winter and spring, and effect children more frequently than adults. The fulminant form develops abruptly, the symptoms are very severe, and leads to a fatal termination in a few hours. Headache is a constant feature in the common form and is accompanied by intolerence of light and noise. A chill and vomiting are the first symptoms noticed. The temperature may become high, but does not necessarily bear any relation to the severity of the case. Abortive cases occur. In mild forms the duration is from four to five days. In the malignant form, if recovery takes place at all it, is after a long severe illness complicated by involvement of the special senses, and followed by many sequelae. Mortality is from 25 to 50 per cent, being very high in young children. The sick-room should be darkened, noise and excitement avoided. The diet should be liquid and nutritious. The treatment advised consists of narcotics followed after effusion has taken place by iodides and mercury. The ice-bag is very useful.

Monographs on Nervous Diseases

With Especial Reference to Hygiene, Nursing and Therapeutics.

Angio-Neurotic Edema.

By F. Savary Pearce, M. D.,

PHILADELPHIA,

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IS a condition of edema occurring along the course of nerve trunks and dependent upon a neurosis. Angio-neurotic edema occurs more frequently in early middle life, is a somewhat painful swelling, occurs in any locality of the body rather than in any dependent parts or in little supported cellular tissues, as is the rule with edema from heart or kidney disease. Such edema, too, does not disappear as do other forms of edema by position of the body or depending more upon the condition of vasomotor paresis of the part affected. There is usually the history of some hereditary nervous disease in the ancestry. The edema appears suddenly and is usually circumscribed; it may occur in the face, the eyelids, lips, or cheek, but may appear in the backs of the hands, legs or in the throat. The condition is usually transient and may be associated with gastro-intestinal distress. Generally there is marked periodicity as in one case reported by Matas where the attack appeared every morning between eleven and twelve. Occasionally the attacks are preceded by heat, itching, redness or in some instances, urticaria. Sudden edema of the larynx may prove fatal. The colic accompanying this neurosis is usually intense. The disease is allied to urticaria and certain forms of purpura, i. e., those accompanied by urticarial manifestations. Quincke considers the edema of vasomotor origin. A neurosis under the influence of which the permeability of the vessels is suddenly increased.

The *treatment* of the condition would depend upon the cure of the neurosis. The rest treatment would be ideal. Tonics are also indicated, and particularly doses of strychnine; if anemia exists, hematics would be of value through reconstruction of the blood. Continued doses of ergotin may be of some benefit. Frequently the disease resists all therapeusis; or if the patient survives the exacerbations of the disease, which, as mentioned above, may be located in a vital part as the larynx, he may "outgrow" this manifestation of a neurosis of the gravest form.

The International Congress of Gynecology at Rome.—At this congress, which is to be held September 15 to 21, the first address to be delivered will be upon the medical indications for inducing delivery. by Dr. Barton Cooke Hirst, of Philadelphia. Among the other papers to be read is one on the surgical treatment of cancer of the uterus, by Dr. Cullen, of Baltimore.

MENTAL AND NERVOUS DISEASES.

By Frank Parsons Norbury, M. D.,

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and Egbert W. Fell, B. S.,

JACKSONVILLE, ILL.

Puerperal Insanity (Hirsch, Med. Record).—This does not exist as a specific form of mental disease, the disorders occurring during gestation being the same as those seen in other patients. Pregnancy may under certain circumstances act as an etiological factor in insanity. Psychoses occurring in connection with parturition are produced by trauma, by anemia or exhaustion after hemorrhage, or by intoxication in septic cases or uremia. The form is usually an acute delirium which may recover in a short time or pass into a secondary psychosis. Lactation, as such, plays no role in the production of insanity.

Neurological Observations in the Hawaiian Islands (Brower, Med. News).—The general effect of the climate on the Anglo-Saxon, at the sea level, is depressing, neurasthenia being not uncommon. The uniformity of temperature is beneficial in the spinal scloroses, these being less common than in this country. The types of insanity are mild, the proportion being about one to a thousand. It is not usual to have violent mania, and general paresis and paranoia are unknown in natives. Suicide is very rare. Lepers are segregated on the island of Moloki, there being 1200 here at present. This disease is regarded as purely contagious, being transmitted by the nasal and oral secretions, its rapid spread being counted for by their lowered resistance of the natives caused by the great prevalence of syphilis, and their socialistic tendencies. About 25 per cent of cases are of the nervous or anesthetic form. These cases begin with an erythematous eruption and hyperesthesia which gives place to anesthesia and then to motor symptoms. The ulnar and peroneal are the usual seats of attack, the invasion of the ulnar producing the characteristic claw hand. It is probable that the bacillus begins its work in the sensory end organ of the skin and traveling up the nerve involving the motor filaments as well, thus producing muscular atrophy and contraction. The nerve is enlarged and nodular. In some cases the symptoms were much like Reynaud's disease and syringomyelia. The anesthetic cases are long lived, the tuberculous, short. The treatment is mildly tonic, alterative and when necessary anodyne, strychnine and hot baths have been followed by good results. Climate seems to exercise an influence over the progression of the disease.

The Early Diagnosis of Idiocy, with Case (West. Columbus Med. Jour.)—Instruction of this class of patients should be begun early by the

parents and afterward they should be removed to an institution. The first class considered by the author is that of the so-called Mongolian idiots, a case being presented. In these patients the head is smaller than normal, and they are generally short in stature Eyes are oblique and watery, nose flat over the bridge, lips thick and rough, teeth and breath bad, tongue rough and furrowed. The hands are short and stubby and the joints remarkably flexible. The breathing is rough, being more pronounced at intervals. Most of the actions are slow. The recognition of this condition even in the first few days of life is not difficult, the child being usually apparently lifeless and very slow to respond to stimuli. Microcephalous and hydrocephalous are easily recognized; the great majority of the latter are mentally deficient. The distinction between hypertrophic and hydrocephalic idiocy is not usually difficult, and should be made, as much can be done for the latter while the former class is hopeless. Prenatal meningitis or other lesions existing before or acquired soon after birth may cause mental impairment accompanied by convulsions, rigidity or paralysis. Although imperfect development and abnormal movements are not pathognomonic of mental taint, the presence of stigmata is of great aid in making the diagnosis. On the borderland is the class of children designated as backward. They are poorly developed in mind and body, they are slow in learning and slow in giving up what they have learned for something better. Some become truly idiotic, other developing into useful citizens, a great deal depending on their early teaching.

The Relation of Meningeal Traumas to Mental Disturbances (Bell. Phys. and Surg.).—The dura mater is composed of an outer fibrous and an inner serous layer. The outer layer is more frequently diseased and a simple inflammation often exists. The dura is also frequently thickened and adherent to the calcarium and may give rise to obstinate headaches. Case I.—Male, 56 years old, of a morose hypochondriacal temperament. About January 16 he complained of pain and swelling of the left side of the face. There was hyperesthesia of the skin and sensitiveness of the mucous membrane. Pain along the upper maxillary division, along the auriculo-temporal nerve and over the temporal bone was intense. Mastication and talking were painful. Patient was extremely nervous and forgetful. Cocaine, nitroglycerine, gelsemium and soothing applications failed to relieve the pain. Illusions of hearing, and sight were developed, pain increased and changed to coronoid process. The mental disturbance increased the patient being violent at times. No abscess could be located. Pulse 84, volume very much decreased. Sensation in extremities and locomotion impaired. Delusions were marked. Death from cardiac failure. The post-mortem reveal a thickened dura firmly adherent to the inner table, and also to pia along the longitudinal fissure. A large abscess cavity was found behind the inner angle and ramus of the inferior maxillary extending up to base of skull. The adhesions were of a chronic nature of long standing and probably caused by sepsis or streptococcus meningitis. The mental symptoms may be attributed to the involvement of the external carotid interfering with nutrition. Case II.—As the result of a fall the internal angular process of the supraorbital sack of the frontal bone was

fractured, compressing the cerebral substance and causing the eyeball to protrude. The bone was elevated and meninges replaced. Patient was in a comatose condition, but recovered; the mind remained impaired. Case III. and the one following illustrates a type which might be called psychotraumatic insanity. Immediately following financial reverses the patient, a lady, developed delusions of persecution. She was very reticent and suffered from periods of nervous depression. Great improvement followed change of surroundings. Case IV was a lady who developed a mental aberration after the sudden death of her husband. The patient was neurasthenic and bad disturbance of the vasomotor system and general weakness. Reflexes were exaggerated. There was constant fear of impending danger, hallucinations of hearing and insomnia.

A Case of Paraesthesia Sexualis with Anthropophagous Practices, showing Lesion Pointing to the Angular Gyrus as to the Probable Cortical Centre of the Sexual Instinct (Styel, Va. Med. Semi-Mo.)—Louis August, German, a soldier, aged 26, while intoxicated, murdered a prostitute in a foul and disgusting manner She was found perfectly nude with an incision in the right iliac region through which the intestines, tubes and ovaries had been removed. The intestines were torn up and scattered about the room, but the tubes and ovaries could not be found. When convicted of the murder August committed suicide. There were no stigmata of degeneration except the serrated teeth of Ferguson, motor functions normal cremasteric reflex much exaggerated. Examination of the brain showed nothing abnormal except a small sac about half an inch in diameter and filled with fluid, in the anterior part of the angular gyrus. There was no evidence of faulty cerebration, and the author explains the perverted sexual act in the following manner. The centres of the sexual organs in the lumbar cord are in connection with a centre in the cortex. The lesion in this case points to the angular gyrus as the location of this center, the lesion causing a departure of the stimuli from their accustomed paths of travel, resulting in perverted feelings and the inhibitory power of the will having been removed by alcoholic intoxication, the perverted act was the result.

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An Accurate Sugar Test.—The progress of medicine is nowhere more evident than in the modern methods of conducting an urinalysis, the day of questionable solutions of indefinite age and activity is past, the profession of today wants only that which is accurate and rapid. The solution ammonio-cupric sulphate, generally known as Whitney's reagent, meets this demand in so far as the test for sugar is concerned and is now generally used. This solution is delicately graduated in strength, so that one drachm is decolorized by 1-30 grain of glucose, exactness of strength makes accuracy certain and the definite quantity of sugar present may be determined in less time than was formerly devoted to determining sugar without thought of the quantity. The solution as manufactured is stable if protected from the air and light; to provide for this the manufacturers, the Norwood Chemical Co., of New York, put it up in colored bottles carefully corked with rubber, from which it should not be removed except as used.

AMONG THE MAGAZINES

The Review of Reviews for August continues its series of invaluable portraitures of men prominent in public life throughout the world. The Rt. Hon. Arthur J. Balfour, just called to the premiership of the British Empire, is the subject of an admirable character sketch by Mr. A. Maurice Low, a writer whose acquaintance with British politics and politicians attests the value of an article from his pen on such a subject. Mr. W. T. Stead relates a most interesting interview recently held with Mr. George Frederick Watts, A.R.A., the only British artist deemed worthy by King Edward of a membership in the new Order of Merit, just established. Mr. Walter Wellman, in an article on "Spooner of Wisconsin," writes in an appreciative vein of the man who by common consent ranks today as the leader of the United States Senate, so far as that body may be said to have a leader. Each of these three men, whose careers are described in the August Review, is at this moment very decidedly "in the public eye." The Review prints these sketches of them just at the right time. "The New Rice-Farming in the South" is the title of an article by Day Allen Willey is also a feature of this issue, which is likely to prove an eye-opener to many readers who have underestimated the recent remarkable developments in Southern agriculture. That rice on the prairies of Louisiana and Texas is now seeded, harvested and threshed by machinery like that employed for wheat on the prairies of Kansas is only one of the facts brought out in this article by (text and pictures) which are likely to cause a ripple of surprise among Northern and Western readers.

Everyone almost has seen a circus as it appears from a seat in the tent, but there are few who have traveled with the company day and night, studied the inner life of the circus folk and the thousand details that make up the organization of a modern circus. The August Cosmopolitan's article "The Organization of a Modern Circus," elaborately illustrated with photos specially taken by the Cosmopolitan's staff photographer, reads to the layman like a chapter from the Arabian Nights. Much has been written about how America's millionaires accumulate wealth in their business hours, but little has been said about how these interesting individuals spend their millions in their hours of leisure. The August Cosmopolitan's illustrated article on "Diversions of Some Millionaires," gives an interesting view of this side of the millionaire's life. Almost everyone who has read H. G. Wells' scientific romances, has felt that they had a peculiar quality of reasonableness all the author's own. One does not find in Mr. Wells' work the burlesque scenes and farcial characters of Jules Verne's work. The great difference between Jules Verne and Mr. Wells is that the latter was trained in scientific methods of thought, while the former was not. Before Jules Verne took to romances he wrote operatic libretti; before Mr. Wells took to romances he was a pupil of Huxley in the Royal College of Science. The Cosmopolitan for August presents an article on Mr. Wells and his work which will prove interesting, not only to those who have read this author's books, but also to those for whom this pleasure is in store.

ALTHOUGH the August Century is a midsummer holiday number, with colored cover and with illustrations in color, the general reader will be likely to turn first to the articles relating to the West Indian disasters. These include contemporary records of the action of both volcanoes from day to day, almost from hour to hour. The Martinique material is grouped under the title "The Last Days of St. Pierre" and comprises (1) a long and specific letter from the Vicar-General of Martinique to the absent Bishop, written in the form of a journal and covering the days from May 2d to 21st, the eruption being on the 8th, and (2) a reprint of the evening newspaper of St. Pierre, "Les Colonies," for the week of May 1-7, or so much of it as relates to "Life in the Doomed City," as the article is called. These two documents were preserved through the forethought of Chaplain MacGrail of the Dixie, and although a portion of "Les Colonies" was given by him to newspaper correspondents, much the larger part is entirely new to the American reader. The letter and the newspaper extracts together make a vivid and authoritative record of historic interest and value. "The Catastrophe in St. Vincent" is treated by S. C. Reid, who furnishes introductions and notes to two narratives (1) by the Chief of Police, Captain Calder, and (2) by T. McGregor McDonald, proprietor of the Richmond Vale estate, which was overwhelmed by the volcanic scourge. Each of these gentlemen had a narrow escape, which is here described, and each made particular record of the phenomena of the eruptions of La Soufriere as they occurred. For comparison with these documents the editor reprints the younger Pliny's account of "The Eruption of Vesuvius," the only source of direct knowledge of the event which exists. The reader is prepared for these articles by a general paper on "Earthquakes and Volcanoes" by James Furman Kemp, Professor of Geology in Columbia University, which is fully illustrated by pictures and sketches, and deals in large measure with the Charleston earthquake and American volcanoes.

THE budget of good things in the August St. Nicholas is sufficiently well assorted to tickle the fancy of all sorts and conditions of children. "Tom Jarnagan, Jr.," is the long story. It is vigorous, natural and decidedly interesting. "Slimme Sir Marmaduke" is a delightful bit of nonsense verse, setting forth the adventures of a very thin knight who in his armor was mistaken for the fire-tongs by the giant's wife. "The Little Maid of the Sea" is a charming story of a fisher lass who mended the nets and took care of her baby brothers and cooked her father's dinner and was cheerful in her work. The League with its prize contests in writing and drawing continues to grow in popularity. These are a few of the many good things in the August number.

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Medical Book News.—A new journal devoted to the interests of the doctor's library has lately made its appearance. It is edited and published by P. Blakiston's Son & Co., of Philadelphia. The journal will appear twice monthly and will be devoted to reviews and description of all that is best in American and English medical literature, the work of all publishers being handled impartially. Each issue will contain a list of most recent and works in press. That the News will be appreciated by library builders goes without saying. It will be sent gratis to those making application.

Fortnightlettes

Says He Has Tuberculosis.—Dr. Paul Garnault, the young French physician who inoculated his arm externally with glandular matter from a tuberculous cow, June 17, and again July 15, subcutaneously, with caseous matter from the liver of a cow with tuberculosis, announced July 21, that tubercles had developed. The second inoculation was performed because he feared that the skin tuberculosis from the first application might remain superficial too long.

The Next Surgeon-General of the Army.—It is announced that the President has designated Col. R. M. O'Reilly to be surgeon-general of the army to succeed General Forwood, who will retire on September 7 next. Colonel O'Reilly will have until January, 1909, to serve as surgeon-general. He was appointed from Pennsylvania as a medical cadet in 1864. He is a graduate of the medical department of the University of Pennsylvania. Gen. Forwood was but recently made surgeon-general, succeeding General Sternberg.

Half a Million for New York Hospital.—Among the bequests made in the will of the late Mary J. Walker, of New York, $100,000 is devised to St. Luke's Hospital, and $25,000 to each of the following named institutions: Home for Incurables, Fordham; Colored Home and Hospital of the City of New York; New York Institution for the Blind; St. Luke's Hospital for Indigent Christian Females, and $15,000 to the New York Society for the Relief of the Ruptured and Crippled. These with bequests to other charitable institutions amount to the sum of $525,000.

First Aid Instruction.—Dr. John E. Owens, Chief of the surgical department of the Chicago and Northwestern Railway, has inaugurated a system whereby all of the conductors, engineers, firemen and brakemen are to be familiarized with the principles of first aid to the injured. These employes will each be furnished with a kit of necessary materials for dressing wounds. On each train, freight as well as passenger, large kits of simple but necessary surgical instruments, bandages, antiseptic dressings, and remedies will be placed, so that in the event of a wreck or serious accident immediate treatment can be given to the injured.

The Coronation Honor List.—The following are the medical men knighted and honored in other ways in celebration of the postponed coronation of Edward VII: Lord Lister has been made a Privy Councillor; Sir Francis Laking and Sir Frederick Treves have had baronetcies conferred upon them; knighthood has been conferred upon Dr. W. J. Collins, Mr. Alfred Cooper, Dr. J. Halliday Croom, Dr. Conan Doyle, Dr. Thomas Fraser, Mr. Victor Horsley, Mr. H. G. Howse, Mr. H. B. Longhurst, Professor William Macewen, Dr. Isambard Owen and Professor Rucker; Sir William Church and Professor Ramsay have been made Knights Commanders, and Major Ronald Ross and Dr. Whitelegge, Companions of the Order of the Bath; Lord Lister has also been appointed to the new "Order of Merit."—*Med. Record.*

MEDICAL MEMORANDA.

Ergoapiol (Smith) in Diseases of the Female (By Charles H. Shepard, M. D., Physician to Lincoln Hospital, Durham, N. C).—deep and general interest is attached to all knowledge pertaining to the treatment of common diseases of the uterus, to which women are subject, and a vast literature is the outcome of this profound and focussed interest. We live today in an age of transition—a period of change. A great many of the former theories in medicine are fast passing away. New medicines are made, achieve a short-lived success, and then pass on to obscurity. This is true especially in medicines for gynecological diseases. Of the newer remedies it is hard indeed to get one that may be depended upon for long. They soon lose their reputation and potency and are relegated to the past. We know that all diseases of the womb have not the same etiology nor the same pathology, therefore they should not all have the same treatment. Far too often the general practitioner groups all these diseases together as one and gives the routine treatment. It is not enough to give anodyne medicines for dysmenorrhea no more than it is sufficient to treat alike all forms of dysmenorrhea. The operation of curettement has a most important place in these conditions, but like other remedial agencies it has its limitation. When we curette the uterus we rid it of a pathologically obnoxious lining membrane, and afford a normal membrane the opportunity to be formed. The healthy woman with normal genitalia menstruates regularly and painlessly once a month from puberty to the "turn" of life, except that this regularity is interrupted by pregnancy and afterwards by lactation. Any departure from this rule constitutes an abnormality. Amenorrhea is less frequently met with than dysmenorrhea and irregular menstruation. The present age of transition has brought forth what is popularly known as the "new woman," and she has brought with her new ideas and practices which in very many cases retard growth and the natural process necesary for perfect health. For leaving the old landmarks, she has to suffer. The most generally useful medicine in the conditions of amenorrhea, dysmenorrhea, irregular, scanty and fetid menstruation, in my judgment, is a preparation of the Martin H. Smith Company of New York, known as ergoapiol (Smith). In the female ward of the Lincoln Hospital, Durham, N. C., I have used this medicine very extensively, and it has not only never failed to benefit and cure, but I know no remedy with which I could replace it were I deprived of it. Its efficacy may be tested by any physician who properly tries it. I mention a few cases with short description of each, in which it has given the most signal benefit in my hands. Ergoapiol (Smith) is put up as a small capsule, and is made up of a special form of apiol which is of the very highest quality. Combined with this are some other most valuable hemagogues and they all go to make a fine preparation. It seems to be a scientific pharmaceutical preparation, non-toxic, tonic, as well as emmenagogue. What I have to say of this preparation is based entirely upon clinical experience, and I feel safe in saying that it will bear a clinical test whenever properly administered.

No. I. Mrs. F. was admitted to hospital September 15, 1901; married; no children, though she had been married four years. Had not menstruated for seven years. Womb had been curetted several times; suffered from leucorrhea; pains in right and left iliac regions continuous. Examination showed a very small os, but generative organs were otherwise

found to be normal. Another curettement failed to bring on the menses. I then prescribed ergoapiol (Smith) to be taken one globule three times a day, and afterwards increase to one globule four times a day. After seven days of this treatment she complained of a general feeling of stiffness in her limbs, gaping and a feeling of malaise. The following morning she found to her delightful surprise that she was menstruating for the first time in seven years. At that time the flow was somewhat scanty, but the treatment was continued through three periods. Each succeeding period was more nearly normal than the one that preceded it. Now her functions are regular and I know no reason why she may not become pregnant.

Case II.—Mrs. S. complained of a continuous, dull, dragging pain, situated in the region of the iliac fossa of the right side. Menstruation irregular, scanty, fetid. Married six years; had never been pregnant. Excessive leucorrhea, though otherwise she was perfectly normal. Her weight was 140 pounds. Her condition, and the suffering, both physical and mental, which it occasioned her, was rapidly undermining her health. She was becoming emaciated, appetite of no consequence, general weakness. She considered her condition "hopeless." Cardiac weakness, of which she was a victim, contraindicated curettement—which usually cures "whites" and allows the formation of a healthy lining membrane. Ergoapiol (Smith) was prescribed for her, one capsule three times a day. In conjunction with this I gave tonic medicines. After six weeks' use of this remedy, the woman said she was "feeling so good" that she did not need any further treatment. She had increased in weight and her appetite had become all she could wish. The menstrual flow was increased, and now, five periods having elapsed from the time treatment was instituted, her monthly flow has failed to appear. She does not expect its return for some time—supposing herself pregnant.

Ergoapiol has never failed in my hands. It is not possible that it can cure obstructive dysmenorrhea, but with that exception it is indicated in all the other diseases of the womb where a tonic and sedative action is the requirement.

Case III.—Mrs. D., widow; aged 33; had three children; youngest 10 years of age. She had suffered all her menstrual life severe pains in the pelvis at each period; had to keep in bed a week or more each month; paroxysms of pain were followed by a flow of the "whites;" no anemia; womb found to be flabby and relaxed; pains extended down thighs posteriorly. Had been treated for many years by various physicians of note, but had received only temporary benefit. Ergoapiol (Smith) was given her, one capsule three times a day, and increased at the time of the flow to four a day. After three months of this treatment her menstrual function became regular, and being entirely well now, she feels that life, after all, is worth living.

I could prolong this list indefinitely with records of cases that have been entirely relieved of these conditions, and I shall be pleased to furnish any information desired as to ergoapiol (Smith) and its use.

A Contribution to the Therapeutics of Anemic Conditions (By Dr. Hermann Metall, Assistant Physician to the General Polyclinic, Vienna).—In the medicinal treatment of the various forms of anemia, whether it be

essential chlorosis or the so-called secondary forms arising from severe loss of blood and various diseases (tuberculosis, cancer, etc.), iron has always occupied the most prominent place. In the management of chlorosis, especially, the chief object is the administration of an adequate quantity of iron, since upon this depends the success of all treatment. As to the manner in which iron acts in anemic conditions, that is a secondary matter. Whatever be its mode of action, it remains an empirical remedy and yet one of incontestable value. According to the unanimous opinion of many authors the effect of iron in chlorosis cannot be replaced by alimentation. Reinert, Klein, Immermann, Ensli, and others have shown that typical chlorosis cannot be cured in any way, even by forced feeding. Some of them have made a series of very careful experiments for this purpose, and reached the remarkable result that during superalimentation, extending even over a number of weeks, the quantity of hemoglobin in the blood increased scarcely a few per cent, and remained permanently at this level. That this is actually so we daily convince ourselves in cases of chlorosis in girls of the better classes. These girls, if placed on a full diet, accumulate more fat, while the chlorosis remains practically unaffected—it requires iron. The dietary therefore plays a subordinary part in the therapy of chlorosis (Klein), and is to be regarded only as an important adjunct to the treatment. I will now devote a few words to manganese which is employed in combination with iron in some ferruginous preparations for the treatment of anemia. Hannon already directed attention to this metal, which is a constituent of healthy blood, and which besides iron has an important bearing on the absorption of oxygen by the blood. In fact, experiments have shown that anemic conditions are most successfully treated with iron in connection with manganese. Chalybeate medication is materially aided and promoted by the addition of manganese. Efforts have therefore been made to introduce combinations of iron and manganese into therapeutics. After laborious attempts, Dr. Gude, chemist, succeeded in producing such an iron-manganese preparation, which is easily absorbed by the entire intestinal tract, evokes no concomitant effects, and, as is illustrated in the following histories of cases, has proved an excellent remedy for the formation of blood. The preparation referred to is pepto-mangan (Gude). It contains iron and manganese in an organic combination with peptone, and is a clear fluid, resembling dark red wine, of an agreeable, non-metallic, non-astringent taste. The advantage of this preparation is that it exerts a stimulating effect upon the blood-forming organs, these being excited to greater functional activity, and that the favorable effect manifests itself even within a short time by an increased oxygenation of the blood. At the same time, this chalybeate, as already mentioned, causes no digestive disturbances and does not injure the teeth. In regard to the daily dose of iron, Quincke maintains that it should range from $\frac{3}{4}$ to $1\frac{1}{2}$ grains of Fe. Most clinicians prescribe commonly 4 grains, which considerably exceeds the maximum dose recommended by Quincke. Some of them, like Niemayer and Trousseau, give even 7 grains of metallic iron daily; hence pepto-mangan (Gude) should be prescribed in doses of one tablesponful three times daily for adults, and one teaspoonful twice daily for children up to twelve years, after meals. Sour, fatty foods and red wine should be avoided during its administration. The preparation is much relished by all patients, and it is my custom to

administer it to children in water, or, better, in cold milk with the addition of sugar, in which form it is very palatable. After this brief introduction I will describe a number of cases which have been treated by me with pepto-mangan:

Case I.—Mary B., 16 years old, has complained since a week of general debility and lassitude. She is very pale and restless, has no appetite, and suffers from headache and a feeling of pressure in the stomach. She is constipated, and the menses are irregular. Diagnosis, chlorosis. After a week, the appetite was good, no headache; at the end of the second week, no further disturbances; menses not painful, and lasting only three days (formerly five days). After four weeks, the patient discharged cured.

Case II.—Anna H., 23 years old, has suffered for three years from chlorosis, with irregular menstruation, palpitation of the heart, a feeling of weakness, and occasional syncope. Physical examination showed the presence of anemic murmurs over the heart, as well as a venous murmur; no fever or edema. Appearances of menses after absence of twelve weeks: subjective disturbances have disappeared.

Case III.—M. W., 16 years old, has suffered since a year from headaches, dyspnea, tinnitus aurium, vertigo and gastric disturbances. There was marked pallor of the face and of the mucous membranes; systolic murmurs over the mitral and pulmonary valves, with dilatation of the heart. No fever; spleen not palpable. Diagnosis, severe chlorosis. The subjective symptoms rapidly subsided, the appetite improved, and the stools became regular. The menses reappeared in the second week of treatment after having been absent for a year.

Altogether, twenty-three cases of anemia were treated with pepto-mangan (Gude), of which twelve showed a normal hemoglobin per cent of the blood after fourteen days, five after three weeks, and five after a month. On the other hand, one of the patients who had hereditary trouble (her father having suffered from pulmonary disease) was discharged only improved, the blood, after two months' treatment with pepto-mangan (Gude), showing only an increase of hemoglobin to 75 per cent. This was probably a case of tuberculosis which simulated an obstinate or severe chlorosis at its beginning. Furthermore, two cases of acute anemia after profuse hemorrhage were treated with pepto-mangan (Gude). A favorable result was obtained as early as the end of the fifth week. In one instance the patient felt so well that only the fear of further hemorrhage constrained him to stay in bed for another week. In the case of three women who had miscarried during the early months of pregnancy, and were making a very slow recovery from the resulting anemia, I was able to obtain a complete recovery after four weeks' administration of pepto-mangan (Gude). In six other instances of weakness and anemia following acute and chronic disease (tuberculosis, carcinoma, scarlet fever, etc.), a disappearance of the feeling of weakness and a considerable improvement of the general health could be observed in every instance. The histories cited above will afford conclusive evidence of the high therapeutic value of pepto-mangan (Gude). Unpleasant concomitant effects and disagreeable sequelae were never observed during the use of the remedy. Eructations, pressure in the stomach, and nausea were never noticed. In conclusion, I would say that pepto-mangan (Gude) is a valuable and reliable blood-building remedy, which can be recommended for general use in appropriate cases.